Reference Number: *UHB 553* **Version Number:** 1	**Date of Next Review:** *26/05/2026* **Previous Trust/LHB Reference Number:** *N/A*

Clinical Guideline: Seeking a Second Opinion

Introduction and Aim

This clinical guideline has been developed to support:

- *A consistent approach in seeking second opinion in diagnosis and treatment.*
- *More open discussion with patients.*
- *Usual steps if opinions differ.*

Objectives

This clinical guideline has been developed to support:

- *A consistent approach in seeking second opinion in diagnosis and treatment.*
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- *Usual steps if opinions differ.*

Scope

This document relates to all clinical areas within the Mental Health Clinical Board (MHCB). The main emphasis is on medical second opinions, though similar principles may apply for other professional groups.

Equality and Health Impact Assessment	*An Equality and Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this Procedure	*N/A*
Approved by	*Mental Health Clinical Board*

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Disclaimer
If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	*26/05/2023*	*Feb 2026*	*New Document*

CLINICAL GUIDELINES FOR

SEEKING A SECOND OPINION

Contents

1. AIM

1.1 This clinical guideline has been developed to support:

- A consistent approach in seeking second opinion in diagnosis and treatment
- More open discussion with patients
- Usual steps if opinions differ

2. INTRODUCTION

Definition

2.1. ***"Second opinion**: An independent opinion from a senior clinician (who*

might be from another discipline) who has experience of the patient's condition but who is not directly involved in the patient's care. A second opinion should be based on an examination of the patient by the clinician. " Glossary of terms for treatment and care towards the end of life - ethical guidance - GMC (gmc-uk.org)

2.2. Unless specified the term second opinion clinician refers to clinicians employed by Cardiff and Vale UHB.

Background

2.3. *"a review by another psychiatrist may be helpful, even if the advice given is to continue the current approach. The practice of patient care being delivered by sector teams is likely to increase the usefulness of diagnostic and treatment reviews by 'outside' clinicians. …… Despite these advantages, there is considerable reluctance to ask for second opinions among many senior clinicians. This may be because of insecurity, over-confidence, perceived isolation or the influence of the local culture in asking for help, or indeed giving help*". (Nirodi et al, 2003)

2.4. *"In most medical specialties, second opinions are well established and provide a valuable addition to clinical practice, leading to improved quality of care and increased trust in an already ongoing treatment or a future medical intervention. Although use of second opinions in psychiatry is still in the early stages, the high costs of inadequately treated psychiatric disorders on a societal as well as individual level should be a driving force to encourage making second opinions readily available".* (Heuss et al, 2018)

2.5. Second opinions are often an issue in concerns raised with the Mental Health Clinical Board (MHCB)

2.6. Common reasons for second opinion requests include

- cases of uncertainty or disagreement over diagnosis,
- dissatisfaction with the outcome of treatment and / or
- when a patient asks for a different clinician to be involved with their case.

Where a patient, relative or carer requests a second opinion, it is often because of doubts about the consultant's diagnosis and/or proposed course of treatment and wants an opinion of confirmation, or exploration of alternative diagnoses or treatment.

2.7. The GMC states: "*In providing clinical care you must: …. respect the patient's right to seek a second opinion"* (General Medical Council, 2020)

2.8. This clinical guideline has been discussed, commented upon and agreed by the MHCB's Consultant Body.

Mental Health Act 1983 (amended 2007)

2.9. The MHA sets out circumstances where a second opinion is a statutory (legal) requirement with specific reference to second opinions in relation to treatment of detained patients. Part 1V of the Act relates to consent to treatment and Sections 57 and 58 are the most relevant to the question of second opinions.

2.10. Treatments under S58 (ECT or medication after 3 months) require consent or a second opinion from 'a registered medical practitioner appointed for the purposes of this Part of the Act by the Secretary of State'. The less commonly used S57 requires consent and a second opinion specific reference to second opinions in relation to treatment of detained patients. Part IV of the Act relates to consent to treatment.

2.11. The Code of Practice covers consent to treatment for detained patients and statutory second opinions, with paragraphs dealing specifically with the procedure for second opinions and the role of the Second Opinion Appointed Doctor (SOAD).

2.12. The rest of this guidance refers to requests for second opinions outside the terms of the MHA, including non-statutory requests for second opinions on detained patients.

3. SCOPE

3.1. This document relates to all clinical areas within the Mental Health Clinical Board (MHCB)

3.2. The main emphasis is on medical second opinions, though similar principles may apply for other professional groups.

3.3. This clinical guideline does not cover transfer of care arrangements.

3.4. This document does not seek to cover all scenarios where a second opinion may be requested, recognises clinical involvement is multi-disciplinary, and may, involve more than one practitioner.

3.5. The pre-existing involvement of more than one practitioner does not constitute a second opinion in terms of this clinical guideline, though an involved practitioner may legitimately provide an opinion more widely, if acceptable

to all parties.

4. REQUESTS FOR SECOND OPINIONS

4.1. A reasonable request from a patient for a second opinion should not be refused. What constitutes reasonable should be considered on an individual basis, exercising clinical judgement, in a spirit of openness and respect for patient choice.

4.2. Where possible, requests for a second opinion should be made in writing to the responsible consultant. However, requests for second opinions may be made directly to the treating consultant psychiatrist verbally during an appointment or review.

4.3. All written requests should be acknowledged within ten (10) days of receiving the request. Second opinion requests for community patients will usually be treated as if a fresh referral and will be processed within usual timeframes, and prioritisation. Any likely delays should be made clear to the patient and requestor if different. Requests for inpatients should be seen usually within four weeks, but timeframe should be negotiated between referrer and second opinion, with clear rationale for any delays.

4.4. Requests made directly to the treating consultant during an appointment or review should be acknowledged separately or reflected in the output letter from such appointment or review, a copy of which should be sent to the patient.

4.5. Requests for second opinion are likely to come from four sources:

- From patients themselves,
- From the treating clinician
- From third parties (usually relatives or carers)
- From the patient's GP, which will sometimes be at the request of the patient, relative or carer.

4.5.1. <u>Requests from Patients</u>
If the patient has requested the second opinion, then their consent can be generally implied, though it will still be wise to record the prior discussion in the case notes.

4.5.2. <u>Requests from a Clinician</u>
Where the clinician instigates the request, discussion should take place with the with the patient concerned to help understanding (where possible) of what is involved and why the opinion is being sought.

The MHCB suggests second opinions be considered for e.g.:

- informal patients in hospital for longer than three months.
- treatment resistance
- difference of opinion with specialist team (the matter should be dealt in co-operation with the relevant Clinical Director)

4.5.3. Requests from Relatives or Carers

Third party requests can be more contentious and the consent of the patient to the referral is necessary. The exception to this is where a patient lacks mental capacity around their treatment and a relative /carer is acting in their best interest. In determining whether a patient lacks capacity the legal requirements as set out in the Mental Capacity Act 2005 should be adhered to and the process for determining best interest should also be followed.

Other exceptions include where a power of attorney arrangement is active covering health and welfare.

4.5.4. Requests from patient's General Practitioner

Where requests originate from the GP, this usually follows concerns raised by the patient directly with the GP. In a minority of cases, the GP may request a second opinion, if they disagree with proposed management plans. In these cases, a discussion should take place with the GP to clarify areas of dispute and a further discussion should occur with the patient highlighting what has been agreed following the GP request.

The responsible clinician will generally be involved in making the request for another opinion, even if he/she is not the initiator of the request. The responsible clinician should advise the patient the request is for an opinion only.

4.6. In essence, the second opinion should be independent, based ideally on a face to face clinical assessment and relevant other information such as records, by the clinician providing that opinion. In most cases, an immediate colleague is appropriate, as they most likely accessible to requestor and then patient. However, depending on circumstances, it may be appropriate to ask a colleague in the same speciality based at a different location or a consultant from a different speciality, provided they have the necessary expertise.

4.7. The Cardiff University Psychiatry Service (CUPS) is a referral-only clinical service provided jointly through Cardiff University and Cardiff and Vale University Health Board. The CUPS service offers a service, likely to be considered by many patients as independent of the UHB. Note second opinions are offered in the areas of expertise of their team, currently:

- **Mood disorders** – conditions such as depression and bipolar disorder
- **Psychosis in adults** – in relation to conditions such as schizophrenia or borderline personality disorder
- **Perinatal mental health** – mental health problems around pregnancy and childbirth such as post-natal depression
- **Genetic counselling** – advice on the risk of passing down common psychiatric disorders through families
- **Post-traumatic stress disorder** – assessment, treatment and second opinions for people who develop Post-Traumatic Stress Disorder after experiencing traumatic events.

Referrals should be made through: CUPS Clinic Coordinator, Hadyn Ellis Building, Maindy Road, Cardiff, CF24 4HQ

5. REQUESTS FOR OPINIONS OUTSIDE THE UHB

5.1. Requests for an opinion outside the UHB may be appropriate and necessary, but the treating clinician should always consider an internal second opinion first.

5.2. Approaches for external second opinions maybe made informally with neighbouring health boards.

5.3. An external second opinion may be requested to support a referral to a specialist unit outside the UHB (e.g. the Maudsley). In some cases, this request may be clinically appropriate although funding will need to be agreed through the usual processes. This is likely to include IPFR funding.

5.4. Note the patient, or third party, may want an external opinion because they believe a UHB doctor will not, or cannot, provide an independent opinion – e.g. the patient has a grievance with the UHB as a whole or they may feel that all doctors in the UHB are in allegiance and cannot be truly independent. If the UHB can demonstrate reasonable attempts to provide an independent opinion from within the UHB, and this has been unreasonably declined, then the UHB may decline support for an independent external opinion. The patient should of course be made fully aware of the reasoning, their rights to advocacy, and all channels within the Putting Things Right Policy. The treating clinician should seek advice from their Clinical Director, about any required one-off opinion from a consultant outside the UHB, to agree a decision and course of action. The CUPS service (see 3.7) may be seen to be sufficiently independent in some instances Any referral should be for opinion only and any costs should be authorised through the Clinical Board Director.

5.5. Patients are free to pursue external opinions from private practitioners,

who should be afforded the same regard as NHS psychiatrists. Any special areas of expertise should described in received correspondence. Where possible, dialogue should be promoted, with the second opinion doctor, especially if the opinion received, or sought significantly differs to the local treating psychiatrist. With patient permission, clinical information maybe shared with the private doctor.

6. DEALING WITH DISAGREMENTS AND DISPUTES ON SECOND OPINIONS

6.1. In some cases, the patient or third party remain dissatisfied even after a second opinion has been provided, and may request a further review. It is advisable that the treating clinician and the clinician providing the second opinion discuss the position and request and the treating clinician should discuss the matter with the Clinical Director. Such a request may be reasonable, but the treating clinician is now in a stronger position to decline, if they chose to.

6.2. In most cases, the advice given by the second opinion is likely to be helpful to both the patient and the original clinician. However, where the second opinion has been requested by the patient or a third party, this may not be the case. If the clinician providing the second opinion, when completing their assessment, considers their advice will seriously conflict with the opinion and treatment of the original clinician, they must consider the implications of this and not deliberately act in a manner likely to jeopardise / adversely affect the professional relationship between patient and original clinician e.g. being unduly critical of the current treatment plan in communications with the patient / original clinician either verbally or in writing. If the patient wishes to follow the recommendations of the clinician giving the second opinion and the original consultant disagrees with the second opinion, the relevant Clinical Director may assist in mediation and/or another opinion may be sought internally. The Complex Case Forum (CCF) is recommended to ensure a full multidisciplinary perspective in such instances, and a reflective space prior to in exceptional circumstances, consideration of an independent expert opinion from outside the UHB with the agreement of the Clinical Board Director. Note: The CCF will not adjudicate on differences of opinion.

6.3. If the request for a second opinion is of a more specialist nature, or the patient feels that referral to an alternative psychiatrist within the UHB is unacceptable, a referral may be made for a one-off opinion to a Consultant outside the UHB with the prior approval of the Clinical Board Director. This referral would be for opinion only and would not commit the second opinion doctor to taking the patient on for treatment. The opinion of the second opinion doctor should be readily available to the patient. If that

subsequent second opinion is substantially different and the differences cannot be resolved, referral should be made to the Clinical Board Director.

6.4. In cases of dispute or conflict, a request for advice should be made to the relevant Clinical director who may review the cases notes and discuss the case with the treating consultant, if necessary the team looking after the patient and the patient his/herself following which decision will be made about the appropriate course of action.

7. REFUSING A REQUEST FOR A SECOND OPINION

7.1. In some circumstances, it may be appropriate to refuse a request for second opinion. e.g. a patient who is detained in hospital who does not accept they are ill and where the MDT agree a second opinion would not be therapeutic and may re-enforce a patient's difficulty in engaging with treatment/the clinical team. In such an instance the use of the MHA appeals processes is likely more appropriate than a second opinion.

7.2. The decision to refuse a request for a second opinion should be taken only after careful consideration. In these circumstances the should be clearly stated in writing for the patient and documented in the clinical notes. The patient should also be advised to seek support from the advocacy services and be facilitated to do so. All cases in which a request for second opinion is refused should be referred to the Clinical Director who will look at the case notes, discuss the case with the treating consultant and if necessary the team looking after the patient and the patient him/herself, following which a decision will be made about the appropriate course of action.

8. CONCERNS PROCEDURE

8.1. MHCB staff should not advise patients to use the concerns procedure to obtain a second opinion or alternative consultant. However, if the patient does not think that their request or concern has been adequately addressed they may to wish to take this matter further by using the concerns procedure.

9. IMPLEMENTATION

9.1. All clinical directorates are responsible for implementing this clinical guideline.

9.2. This clinical guideline should be included in the induction programme for all medical staff.

10. MONITORING AND REVIEW

10.1. The Clinical Board Director is responsible for monitoring and the review of this clinical guideline.